STATE BOARD OF EXAMINERS FOR
SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

Mailing address - documentation only
1100 West 49th Street
Austin, Texas 78756-3183
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Physical Address
Mail not delivered to this address
8407 Wall Street, S -420
Austin, Texas 78754
WWW.TDH.STATE.TX.US/HCQS/PLC/SPEECH.HTM

Mailing address - documentation accompanied by a fee (include budget and fund as noted above)
P.O. Box 12197
Capital Station
Austin, Texas 78711-2197

TO: ASSISTANT IN SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY AND LICENSED TRAINER

FROM: DOCUMENTATION THAT MUST BE PROVIDED UPON COMPLETION OF THE 25 HOURS OR CLINICAL OBSERVATION AND/OR 25 HOURS OF CLINICAL ASSISTING EXPERIENCE

The training may not begin until the assistant license has been issued and must be completed within 60 days of the issue date of the assistant's license.

The licensed trainer must submit:

_____ **Logs** that verify the **specific times and dates** the hours were acquired with a **brief description** of what training was conducted.
(NOTE: You may use the Supervision Log prepared by the board office or develop one of your own; however, all items listed on the board form must be included on your form.)

_____ **Statement of Completion of Training for Assistant Form** verifying that the assistant **successfully completed** the observation and/or clinical assisting experience (include number of hours) under your **100% supervision**.

_____ **Rating Scale of Assistance's Performance Form**.

(NOTE: The above documentation **must be signed by the licensed trainer** (speech-language pathologist or audiologist) who conducted the training defined in the plan approved by the board office.)

The licensed assistant must submit:

_____ A signed statement that clearly shows he or she understands the **duties (list them)** that may and may not be performed as an assistant. The assistant should also include a statement that clearly shows he or she understands that a licensed speech-language pathologist or audiologist must submit the board **form accepting responsibility** for the assistant's practice before the assistant may practice. This form is required upon application, with a change of supervisor and upon renewal of the license.

STATEMENT OF COMPLETION OF TRAINING FOR ASSISTANTS FORM

CLINICAL OBSERVATION

I, the undersigned, provided the opportunity for _____ to observe
(Name of Assistant)
me for _____ hours while I conducted:
(give #)

therapy
other (list) _____

_____

in order to earn the _____ hours of clinical observation.
(give #)

CLINICAL ASSISTING EXPERIENCE

I, the undersigned, provided 100% (face-to-face) supervision for _____
(Name of Assistant)
to acquire _____ hours of clinical assisting experience as evidenced on the supervision log.
(give #)

This training was completed successfully and included the items listed on the proposed plan as follows (indicate areas of training):

conduct or participate in speech, language, and/or hearing screening;
implement the treatment program or the individual education plan (IEP) designed by the licensed speech-language pathologist;
provide carry-over activities which are the therapeutically designed transfer of a newly acquired communication ability to other contexts and situations;
collect data;
administer routine tests as defined by the board;
maintain clinical records;
prepare clinical materials; and
participate with the licensed speech-language pathologist in research projects, staff development, public relations programs, or similar activities as designated and supervised by the licensed speech-language pathologist.

_____ _____
Date Signature of Trainer/Supervisor

_____ _____
Date Signature of Assistant

RATING SCALE OF ASSISTANT'S PERFORMANCE FORM

I, the undersigned, provided 100% supervised training of _____
(Name of Assistant)

The assistant's performance is rated as follows:

4=Excellent
3=Good
2=Fair
1=Poor

1. Implement treatment programs _____
2. Data collection _____
3. Administer routine tests _____
4. Prepare clinical materials _____
5. Maintain clinical records _____
6. Participation in speech, language, and hearing screenings _____
7. Maintain professionalism _____
8. Efficient use of time _____

_____ _____
Date Print Name of Trainer

_____ _____
Date Signature of Trainer

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SUPERVISION LOG FOR ASSISTANT'S PERFORMANCE IN SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY FORM

Name of assistant: _____ **License #:** _____

Name of supervising Speech-Language Pathologist: _____ **License #:** _____

DATE	TIME BEGIN – END	ACTIVITY	SUPER-VISION D/I*	COMMENTS	SIGNATURES

*Indicate Direct or Indirect supervision

form 8-assistant supervision log
revised 07/01

To file a consumer complaint 1-800-942-5540
P.O. Box 141369 Austin, Texas 78714-1369
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